TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Commerce & Industry Insurance

MFDR Tracking Number
M4-15-4225-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $339.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "it is the carrier's position for dates of service 06/06/2014 and 08/01/2014, Rule 133.307(c) (1) (A), states a request for MFD that does not involve issues identified in subparagraph (B) of this shall be filed no later than one year after date (s) of service in dispute. Additionally, for date of service 06/06/2014, 08/01/2014 and 10/17/2014, the carrier contends these bills were denied correctly. This appears to be a staff meeting."

Response Submitted by: AIG, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2014 August 1, 2014 October 17, 2014	99361	$339.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for workers compensation specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - Payment for case management services requires documentation that the services have been rendered in accordance with 134.202(e)(3)
   - No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Were all the dates of service submitted to MFDR timely?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 (c) (1)states,

   A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph

   (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   Review of the submitted information finds:

   Date of service in dispute June 6, 2014 – Received MFDR request August 28, 2015

   Date of service in dispute August 1, 2014 – Received MFDR request August 28, 2015

   Date of service in dispute October 17, 2014 – Received MFDR request August 28, 2015

   Pursuant to Rule 133.307 dates of service June 6, 2014 and August 1, 2014 were received later than one year from the date of service the requestor has waived the right to MFDR for these dates of service. Therefore only the October 17, 2014, date of service will be considered in the MFDR request.

2. The insurance carrier denied date of service October 17, 2014 as, "Payment for case management services requires documentation that the services have been rendered in accordance with 134.202(e)(3)." 28 Texas Administrative Code §134.204 (e) states,

   Case Management Responsibilities by the Treating Doctor is as follows:

   (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

   (A) Team members shall not be employees of the treating doctor.

   (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

   (2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

   (3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

   (A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

   (B) developing or revising a treatment plan, including any treatment plans required by Division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added

Review of the submitted information finds:

- Healthcare professionals that participated; Jacqueline Allender, LMT, Norma Bustos, CA, Yvonee Reyes, CA, and Sigla Lazalde, CA
- Treatment plan: “Pending report from that visit”

The submitted documentation is insufficient to identify the conference was triggered by a documented change in the condition of the injured employee and was performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. For that reason, the insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

3. The requirements of Rule 134.204(e) were not met. No separate reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.